

PRE – EMPLOYMENT MEDICAL QUESTIONNAIRE

Full Name:

Address:

Contact No:

We will not contact your doctor without your prior written consent.

1. How many days' absence have you had from work in the last three years?	days
2. Are you currently on medication (excluding contraceptives)? If YES, please give further details.	YES/NO
3. Have you spent time in hospital in the last three years? If so, why?	YES/NO
4. Do you suffer from any injury, illness, medical condition or allergy that might affect your ability to perform your duties? If YES, please give further details.	YES/NO
5. Do you consider yourself to have a disability? If YES, please give further details.	YES/NO

Data Protection Notice:

The Company requires certain information prior to you commencing employment, to ensure you will be able to perform the requirements of the job and give reliable service, and to ensure compliance with relevant Health and Safety regulations. The information is also required in order to establish whether any reasonable adjustments may need to be made to assist you in performing your duties, in accordance with the Disability Discrimination Act 1995.

The information you provide will be treated in the strictest confidence, and used only for the purposes detailed above in compliance with the Data Protection Act 1998.

Signature:	Date:
------------	-------